

**Wisconsin Health Insurance Risk Sharing Plan (HIRSP)  
Health Insurance  
Policyholder Claim Form**

DO NOT WRITE IN THIS SPACE (ICN)

Please print clearly. Use this form for claims that do not include prescription drugs. Include itemized statement(s) for all charges on this claim. Submit as many claim forms as necessary for the services received. See reverse for detailed instructions.

**Policyholder Information**

1. Last Name		First Name	Middle Initial	2. HIRSP Identification Number		3. Date of Birth	
4. Address, Number and Street				City	State	ZIP Code	5. Sex <input type="checkbox"/> F <input type="checkbox"/> M
6. Group Name <b>HIRSP</b>				7. Daytime Telephone Number ( ) -		8. New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Are you currently covered by another medical plan?  Other Health Insurance Plan <input type="checkbox"/> No <input type="checkbox"/> Yes Medicare <input type="checkbox"/> No <input type="checkbox"/> Yes  If "YES," give identification number and effective date.  Identification Number _____ Effective Date _____				10. Was Treatment For: Accident at Work <input type="checkbox"/> No <input type="checkbox"/> Yes Other Accident <input type="checkbox"/> No <input type="checkbox"/> Yes  Date of Accident (MM/DD/YYYY) _____  Name of Policyholder _____ Name of Other Insurance _____ Address of Other Insurance _____  Please attach a copy of the Explanation of Benefits from other insurance carrier.			

**Medical Claim Information**

11. A. PRIOR AUTHORIZATION NUMBER			B. DESCRIPTION OF ILLNESS				
C. FROM DATE OF SERVICE	D. TO DATE OF SERVICE	E. QUANTITY	F. CHARGE \$		G. PROCEDURE CODE		
H. DESCRIPTION OF SERVICE			I. POS	J. PROVIDER NAME			
A. PRIOR AUTHORIZATION NUMBER			B. DESCRIPTION OF ILLNESS				
C. FROM DATE OF SERVICE	D. TO DATE OF SERVICE	E. QUANTITY	F. CHARGE \$		G. PROCEDURE CODE		
H. DESCRIPTION OF SERVICE			I. POS	J. PROVIDER NAME			
12. Total Number of Bills Attached _____ Total Charges \$ _____							

**Policyholder Signature and Payment Designation**

13. I certify the above information is correct and that charges were incurred by the above named policyholder.		Make Payment To: <input type="checkbox"/> Policyholder <input type="checkbox"/> Provider If to provider, complete Assignment of Benefits below.
Policyholder's Signature _____	Date _____	

**Assignment of Benefits**

14. I hereby authorize the HIRSP Plan Administrator to make payment directly to the provider for the services described above.			
Policyholder's Signature _____			Date _____
Physician's or Supplier's Name and Address _____			
City	State	ZIP Code	Provider Number

Submit with itemized statement(s) to:

**Wisconsin Health Insurance Risk Sharing Plan  
Suite 18, 6406 Bridge Road, Madison, WI 53784-0018  
(608) 221-4551 (local) 1-800-828-4777 (toll free)**

# Instructions for the Policyholder Medical Claim Form

If you have a claim for prescription drugs, please complete the HIRSP Policyholder Drug Claim Form.

- |                             |  |
|-----------------------------|--|
| 1. Name                     | Enter your full name.  |
| 2. Identification Number    | Copy the number indicated on your HIRSP identification card.   |
| 3. Date of Birth            | Enter month, day, and year (MM/DD/YYYY), in that order.  |
| 4. Address                  | Enter your complete address.   |
| 5. Sex                      | Check appropriate box (F = female, M = male).  |
| 6. Group Name               | This item has been completed for you.  |
| 7. Daytime Telephone Number | Provide home or work number where you can be reached during the day.   |
| 8. New Address?             | If you have completed this form with a new address, check the "YES" box to update your current policyholder information.                         |
| 9. Other Medical Plan?      | Check the appropriate box(es). Indicate the identification number assigned, effective date, and name and address of the other insurance company. |
| 10. Was Treatment For       | Check the appropriate box. If yes, enter the month, day, and year the accident occurred.   |

## 11. Claim Information

**If you do not know the information requested on this form, please ask your provider.**

- A. Prior Authorization Number — Ask your provider if these services have prior authorization. If yes, indicate the prior authorization number.
- B. Description of Illness — Write in the condition or diagnosis for which you required treatment.
- C. From Date of Service — Enter the month, day, and year you began to receive each service.
- D. To Date of Service — Enter the month, day, and year you stopped receiving each service.
- E. Quantity — Enter the total number of services billed for each line (e.g., 15 minutes of therapy equals a quantity of 1). Refer to your itemized bill for the quantity, or ask your provider.
- F. Charge — Indicate charge for each service.
- G. Procedure Code — Enter the procedure code for the service you received. Please ask your provider for this information if it is not included on your itemized statement.
- H. Description of Service — Record the service provided (e.g., office visit, rental or purchase of equipment, corrective shoes, prosthetic devices, lab, x-rays).
- I. POS — Enter the appropriate place of service code as follows: 0 for other, 2 for outpatient hospital services, 3 for doctor's office, 4 for home (e.g., home health), 7 for nursing home extended care facility, or 8 for skilled nursing facility.
- J. Provider Name — Indicate the name of the health care professional from which you received medical service.

## 12. Total Number of Bills

Indicate the number of itemized statements attached and the total charges.

## 13. Signature

Your signature attests to the accuracy and completeness of all information on the claim. Please date (MM/DD/YYYY) this application in the space provided. Check the appropriate box for paying this claim. If you want payment to go to the provider of services, you must complete the Assignment of Benefits information below.

## 14. Assignment of Benefits

If you want payment to go to the provider of services, sign and complete this section.

**(Note:** You may only include one provider per claim form.)

MAIL THIS FORM TO:

**WISCONSIN HEALTH INSURANCE RISK SHARING PLAN  
SUITE 18  
6406 BRIDGE ROAD  
MADISON, WI 53784-0018**